

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

12209

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

George W. Adams

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. W.

Married

8. (b) Name of husband or wife.....

Mary E. Adams

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... years

Aug. 31, 1881

8. AGE:

Years

Months

Days

If less than one day

64

3

17

hrs. min.

8. Birthplace.....

(Town, county, and state)

Ches co. Md.

10. Usual occupation.....

farmer

11. Industry or business

William D. Adams

MOTHER FATHER

12. Name.....

Ches. Co. Md.

13. Birthplace.....

Sarah Jane Rotey

14. Maiden name.....

Ches. Co. Md.

15. Birthplace.....

Geo. Edwin Adams

16. Informant.....

Waldorf, Md.

Address

17. Burial (Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

St. Paul's

Location.....

Waldorf, Md.

18. Funeral director.....

Hunt & Ryan

Address

Waldorf, Md.

19. Date rec'd by registrar

12-19 1945

M. D. or other

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name w/r.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 18

1945, at 17:15 p.m.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Dec. 17 1945, to Dec. 18 1945, and that I last saw him alive on Dec. 18 1945.

Immediate cause of death.....

Coronary Thrombosis

DURATION

Due to..... Sen. Arterio Sclerosis

G Coronary Heart

Due to..... Disease

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

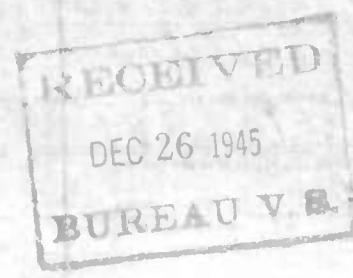
Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed 12-19-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12210

CERTIFICATE OF DEATH

Reg. Dist. No. 103

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male W.

Married

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Feb. 2, 1889

8. AGE:

Years Months Days If less than one day

56 10 21 hrs. min.

9. Birthplace.....

(Town, county and state)

St. Mary's Co. Md.

10. Usual occupation.....

Care Taker

11. Industry or business

Church

12. Name..... Jones Horatio Armsworth

13. Birthplace..... St. Mary Co. Md.

14. Maiden name..... Elizabeth Chellum

15. Birthplace..... St. Mary Co. Md.

16. Informant..... James Cole Armsworth

Address..... Bel. Alton

17. (Burial, cremation, or removal. Which?) Burial Date thereof..... 12/26/45

Cemetery or crematory..... St. Ignatius

Location..... Bel. Alton

18. Funeral director..... Henry & Ryan

Address..... Neddy J. Rd.

19. Rec'd 26 10. 45 Mary E. Burch

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 17-2-3 19-45 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death.....

Coronary Thrombosis 70-3-5

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

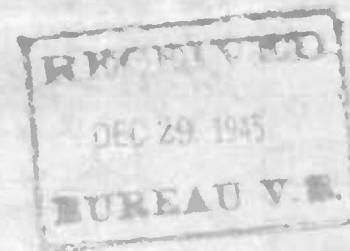
Means of injury

Injured at work?

23. SIGNATURE

B. Edelen M. D. or other

Address..... Date signed..... 12-3-33



RECEIVED

JAN 4 1946

BUREAU V.S.



MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

44-²

CERTIFICATE OF DEATH

12212₇₀

Reg. Dist. No

1. PLACE OF DEATH:		County..... City or town.....		
(If outside city or town limits, write RURAL and give nearest town)				
How long in above place of death?				
Hospital, Institution, or street address where death occurred:				
How long in hospital or institution?				
3. (a) FULL NAME:		Mary Virginia Gilroy		
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced		
<input checked="" type="checkbox"/> F	White	Widowed		
6. (b) Name of husband or wife.		Thomas Gilroy		
7. Birth date of deceased (mo., day, yr.)		6. (c) It alive, give age..... years		
<input checked="" type="checkbox"/> March 19, 1873				
8. AGE:		Years	Months	Days
<input checked="" type="checkbox"/> 72		8		16
				It less than one day
				.hrs. min.
9. Birthplace.....		Charles Co., Maryland (Town, county, and state)		
10. Usual occupation.....		Housewife		
11. Industry or business		Richard Henderson		
12. Name.....				
13. Birthplace		<input checked="" type="checkbox"/> Va.		
14. Maiden name.....		Frances A. Posey		
15. Birthplace		<input checked="" type="checkbox"/> Chas. Co. Md.		
16. Informant.....		Mrs. Allard Bowie		
Address		WELCOME MD		
17. Burial		Date thereof.....	Dec. 8 / 45	
		(Burial, cremation, or removal. Which?)	(month)	(day) (year)
Cemetery or crematory.....		Baptist		
Location.....		BALTIMORE		
18. Funeral director.....		Albert J. Ryan		
Address		WALDORF, MD		
19. (Date rec'd by registrar)		19	45	M. P. MURKIN
				Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County Charles
City or town..... Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH. December 5 1900, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that deceased died from
.....
March 1945, to April 1945
and that I last saw him alive on Dec. 3 1945

Immediate cause of death..... DURATION
Carcinoma of Colon

Due to.....

Due to _____

Other conditions

(Include responses within 9 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results..... _____
PRACTICIAN: Please indicate the areas to which both should be checked statistically.

EXHIBIT B PLEASE DESCRIBE THE CHANGES WHICH WOULD CAUSE NO CHARGE TO BE MADE.

Accident, suicide, or homicide: _____ **Date of:** _____

Where did injury occur? _____

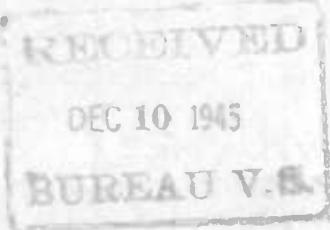
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

2026 RELEASE UNDER E.O. 14176

23. SIGNATURE.....

Address: *Maryland Md* Date signed: *Dec 3 40*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BPA)

12213

CERTIFICATE OF DEATH

Reg. Dist. No. 102

1. PLACE OF DEATH:

County..... *Charles*City or town..... *Dan castor*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Beall Jackson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male**C / Married*

8. (b) Name of husband or wife

Rebecca Jackson

7. Birth date of deceased (mo., day, yr.)

*Feb. 1 1877*6. (c) If alive, give age *66* years

8. AGE:

Years *68*Months *10*Days *8*

If less than one day

hrs.

min.

9. Birthplace.....

Charles Co. Md.

(Town, county, and state)

10. Usual occupation.....

Farmers

11. Industry or business

Bailey Jackson

FATHER

12. Name.....

Charles Co. Md.

MOTHER

13. Birthplace

Felicita Wallace

14. Maiden name

Charles Co. Md.

15. Birthplace

Charles Co. Md.

16. Informant.....

Rebecca Jackson

Address

Dan castor Md.

17. Burial

Date thereof *Dec. 10 1945*

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Mt. Hope.

Location

Waujemoy Md.

18. Funeral director.....

Stanley Penny,

Address

Mason Springs Md.

1945-Dec 9 1945

(Date rec'd by registrar)

d. O. Thompson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Charles*City or town..... *Dan castor* (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Dec. 8 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*1945 Dec 8 1945*and that I last saw him alive on *Dec. 1 1945*

Immediate cause of death

*Cardio-vascular
renal disease.*

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Geo. C. Beckwith M.D.

M. D. or other

Address..... *Morley Md.* Date signed *Dec. 9 1945*



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*Burial
permit*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12214

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Phila. Mem. Hosp. Lettata Md

How long in hospital or institution?

1 day

3. (a) FULL NAME

*Rudolph**Miles*

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Victorine

7. Birth date of deceased (mo., day, yr.)

1881

6. (c) If alive, give age..... years

8. AGE:

64

Years

Months

Days

If less than one day

..... hrs. min.

9. Birthplace

Chas Co Md

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Muskmelon

12. Name

Chas Co Md

13. Birthplace

Chas Co Md

14. Maiden name

Sarah

15. Birthplace

Chas Co Md

16. Informant

Victorine Miles

Address

Waldorf Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Zion Wesley

Location

Waldorf Md

18. Funeral director

Hunt & Ryan

Address

Waldorf Md

19. 12-5

(Date rec'd by registrar)

19-45

Judith Pace

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

City or town

Waldorf

Md

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

12-3

1945

at 17 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-2

1945

to 12-3 1945

and that I last saw h.m. alive on

12-3

1945

Immediate cause of death

Depressed fracture of skull

DURATION

12-7-45

Due to

auto accident

12-7-45

Due to

(Crashers Case)

Other conditions

*Compound comminuted**fracture at tibia and left fibula and**right tibia*

12-2-45

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accident

Date of 12-7-45

Where did injury occur

Waldorf

(City or town) Charles

(County) Md.

(State)

Injured at home, farm, industry, public place (where?)

Public

Means of injury auto hit him while walking

Injured at work

23. SIGNATURE

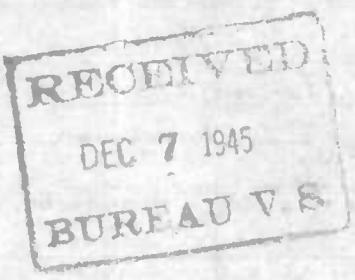
E. Pedersen 12-3

M. D. or other

Address

Lettata Md

Date signed 12-3-45



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

BPA

12215

CERTIFICATE OF DEATH

Reg. Dist. No.

105-

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Audrey Moreland

6. (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

May 11, 1900

8. AGE:

Years Months Days If less than one day
45 6 24 hrs. min.

9. Birthplace

Aquia, St. Louis, Md.
(Town, county, and state)

10. Usual occupation

Manager gas station.

11. Industry or business

William Robert Moreland

12. Name

William Robert Moreland

13. Birthplace

Aquia, St. Louis, Md.

14. Maiden name

Mary Wilkinson

15. Birthplace

Aquia, St. Louis, Md.

16. Informant

P. Harry Moreland

Address

Aquia, St. Louis, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

St. Paul's

Location

Aquia, St. Louis, Md.

18. Funeral director

Hunt & Ryan

Address

Aquia, St. Louis, Md.

19. Date rec'd by registrar

Dec 7 1945 - M. D. MONROE

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Charles

City or town.....

Aquia

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Dec. 4 1945

21. I CERTIFY that death occurred on the date above signed: that I attended deceased from

Jan. 18, 1937 to Dec. 12, 1945

and that I last saw h... in alive on Dec. 14, 1945

Immediate cause of death

Cerebral apoplexy

Due to Cardio-Uar-Neur

Due to Disease with

tly pernicious disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

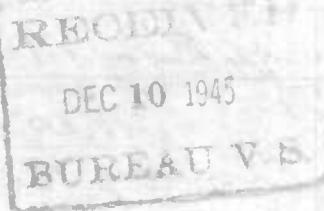
P. J. Walker, M. D.

M.D. or other

Address.....

Aquia, St. Louis, Md.

Date signed



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(Baltimore)*

CERTIFICATE OF DEATH

12215
105
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex *F*5. Color or race *W*6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Robert*

7. Birth date of deceased (mo., day, yr.)

Sept 30th 1867

6. (c) If alive, give age

78

years

8. AGE:

Years <i>74</i>	Months <i>16</i>	Days <i>1</i>	If less than one day hrs. <i>00</i> min. <i>00</i>
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9. Birthplace

Malcolm Chas Co Md

(Town, county, and state)

10. Usual occupation

Horseoyer

11. Industry or business

*George Wilkinson**Malcolm Chas Co**Josephine Lamp**Chas Co**Harry Moreland**Walney Md**Bureau*

(Burial, cremation, or removal, Which?)

Date thereof *12-29-45*

(month) (day) (year)

Cemetery or crematory *s t Peters*Location *Walney Md*16. Funeral director *Hunt & Ryan*Address *Walney Md*19. *12-28-45 M 2 MDE*
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *12/27/45*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/1/37/45 to *12/27/45* at *19*and that I last saw him *alive* on *12/27/45* at *19*

Immediate cause of death

*Garrulous heart trouble**left ventricular strain**due to*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

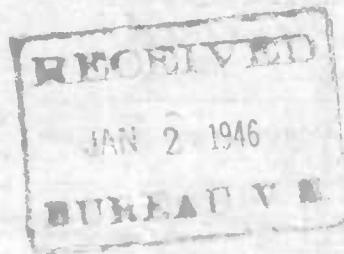
Means of injury

Injured at work?

23. SIGNATURE *Daniel P. Dickey MD*

M. D. or other

Address *Bethesda* Date signed *12/28/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-2

CERTIFICATE OF DEATH

12217

104

Reg. Dist. No.

1. PLACE OF DEATH:

County Newburg Charles CountyCity or town Newburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 68 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

3. (a) FULL NAME

Nannie Mary Shadé4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife George H. Shadé7. Birth date of deceased (mo., day, yr.) December 26th 18778. AGE: Years 68 Months 11 Days 13 If less than one day 15 hrs. min.9. Birthplace Newburg, Charles Maryland
(Town, county, and state)10. Usual occupation Home11. Industry or business Home12. Name Alex Tolosa13. Birthplace Newburg14. Maiden name Eliza Ware15. Birthplace Newburg Md.16. Informant Brooks A. ShadéAddress Newburg17. Burial Date thereof Burial 12/15/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Burial Spiloh CemeteryLocation Spiloh, Md.18. Funeral director Berry and CopeAddress Mt. Pleasant19. (Date rec'd by registrar) 12/15/45 1945 William G. Hare
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town Newburg (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13th 1945 at 3 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9 1945 to December 13 1945 and that I last saw her alive on December 6 1945Immediate cause of death Chronic Myocarditis DURATION 3 years

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Emmett J. Gandy Jr. Esq. M. D. or other _____Address Bethelton Md. Date signed 12/13/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

122185-106
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Charles
Pot. Head, Edin. Head

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

6 months

Hospital, Institution, or street address where death occurred:

44 Greenwood Place

How long in hospital or institution?.....

3. (a) FULL NAME

Macie Edna Simmons

4. Sex

Female White Married

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Jas. H. Simmons

7. Birth date of deceased (mo., day, yr.)

May 29, 1917

6. (c) If alive, give age..... years

8. AGE:

Years 28 Months 6 Days 28 11 less than one day hrs. min.

9. Birthplace.....

Wallace, N.C.

(Town, county, and state)

10. Usual occupation.....

Housewife

own house.

Abbott Sarah

11. Industry or business

Mary D. Cook

Wellesley, N.C.

12. Name.....

James H. Simmons

Address

44 Greenwood Pl. Pot. Head

13. Birthplace

Wallace, N.C.

14. Maiden name.....

Mary Cook

15. Birthplace

Wellesley, N.C.

16. Informant.....

James H. Simmons

Address

44 Greenwood Pl. Pot. Head

17. Burial

Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Family Plot

Cemetery or crematory

Roxie Hill, North Carolina

Location

Hunt & Ryan

18. Funeral director.....

Waldorf Ord. Co.

Address

19. 12-27 1945 M. D. McRae

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No.....

County.....

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 27, 1945 at 6:30 P.M.

19..... to..... December 27, 1945

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Acute myocarditis

Duration..... 1 day.

Due to..... Chronic myocarditis

heart disease

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE

Franklin Susan M. S. M. D. or other

Address.....

Signed..... 12-27-45

RECEIVED

JAN 4 1946

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

RECEIVED

JAN 4 1946

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

12220

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alice Geneva Tippett

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M F W -

Married

6.(b) Name of husband or wife

Joseph Weston Tippett

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

April 27, 1872

8. AGE:

Years Months Days If less than one day
73 7 21 hrs. min.

9. Birthplace.....

New Port, Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

Noble Thompson

FATHER

12. Name.....

Chas. Co. Md.

13. Birthplace.....

Mary Simpson

MOTHER

14. Maiden name.....

Mrs. Jackson Long

15. Birthplace.....

New Port, Md.

16. Informant.....

Burial

Address.....

Date thereof.....
(month) (day) (year)
12/2/45

17. (Burial, cremation, or removal, if any)

St. Mary's

Cemetery or crematory.....

New Port, Md.

Location.....

Grant & Ryan

18. Funeral director.....

Wadlow, Md.

Address.....

19. 12-19 (Date rec'd by registrar)

185 Dr. R. M. Molden

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 12 18 1945 at 11:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-16 1945 to 12-18 1945

and that I last saw h..... alive on

19...

Immediate cause of death.....

Coronary Thrombosis

DURATION

3d 47

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

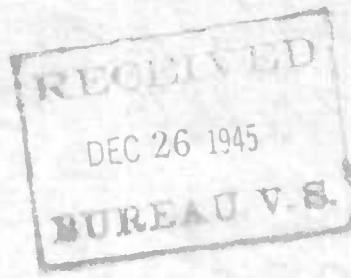
Injured at work?

23. SIGNATURE..... Ernest Spencer Jr. M.D.

M. D. or other

Address..... Bel Alton, Md. Date signed 12-19-45

VS A16



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 100

12221

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH

County

City or town

Charles
new Port

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Henry Whalen

4. Sex

M | 5. Color or race Coal Married

6. (a) Name of husband or wife Alice Whalen

7. Birth date of deceased (mo., day, yr.)

May 7 - 1912

6. (c) If alive, give age 31 years

8. AGE: Years

33 Months Days If less than one day

..... hrs. min.

9. Birthplace

Wicomico County

(Town, county, and state)

10. Usual occupation

Farmer Taber

11. Industry or business

Farm

12. Name

William Henry Whalen

13. Birthplace

Wicomico md

14. Maiden name

Mary Jane Early

15. Birthplace

St. Mary's Co

16. Informant

Alice Whalen

Address

New Port, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 10/45

(month) (day) (year)

Cemetery or crematory

St. Mary's

Location

New Port, Md

18. Funeral director

Wm. H. Ryan

Address

Waelder, Md.

19. Date rec'd by registrar

Dec. 8 1945

M. P. Morris

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Charles

City or town

Newport (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7/45 - 6 AM 19 19

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

12/3/45 19 12/7/45 19

and that I last saw her alive on 12/7/45 19

Immediate cause of death

Lobey pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

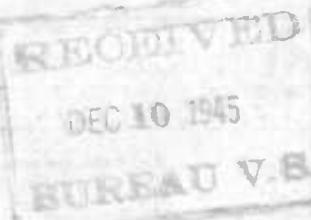
Means of Injury

Injured at work?

23. SIGNATURE

Damele Thibet M. D. or other

Beaufort, NC Date signed 12/7/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

12222

Reg. Dist. No. 101

1. PLACE OF DEATH:

County..... Charles

City or town..... Pisgah

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 1/2 months

Hospital, Institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

Joyce Diane Williams

4. Sex

Female

5. Color or race

Negro

6. (c) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1945

6.(c) If alive, give age years

8. AGE: Years 0 Months 2 Days 22 If less than one day hrs. min.

9. Birthplace..... Wash., D.C. (Town, county, and state)

10. Usual occupation.....

Drafter

11. Industry or business.....

12. Name..... Daniel J. Williams

13. Birthplace..... Pisgah, Md.

14. Maiden name..... H... Ida Mae Harney

15. Birthplace..... Chapel Hill, Md.

16. Informant..... Ida Mae Williams (mother)

Address..... Pisgah, Md.

17. Burial..... Date thereof..... 12/11/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Smith Chapel.

Location..... Pisgah, Md.

18. Funeral director..... Penney & Cofers

Address..... Mason Springs, Md.

19. Dec. 11, 1945, Newbury, Middlesex Co., Reg. No. 101

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Charles

City or town..... Pisgah

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 8,

1945, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 8, 1945, to Dec. 8, 1945,

and that I ~~not~~ saw him die on Dec. 8, 1945.

Immediate cause of death.....

Pneumonia, vascular collapse

Due to..... Probability, labor pneumonia

DURATION

Nine hrs.

Due to.....

Other conditions..... Prematurity (birth wt. 5 lbs)

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op. _____

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... John F. Mackawangh, M.D.

M. D. or other

Address..... Gaithersburg, Md.

Date signed..... 12-8-45

LETTER TO THE STATE DEPARTMENT

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13223
131-G

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles

City or town Sa Plate

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 days

Hospital, Institution, or street address where death occurred:

Physicians Memorial Hospital

How long in hospital or institution? 31 days

3. (a) FULL NAME

Mary Olivia Woodland

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) March 26, 1891

6.(c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
54	9	5	hrs. min.

9. Birthplace CHARLES COUNTY MD

(Town, county, and state)

10. Usual occupation House work

11. Industry or business

12. Name JAHY JOHNSON

13. Birthplace CHARLES CO MD

14. Maiden name MARY JOHNSON

15. Birthplace CHARLES CO MD

16. Informant Florence Banks (daughter)

Address Hughesville, MD

17. Burial Date thereof 1-3-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory S. T. MARYS Cemetery

Location BRYANTON, MD

18. Funeral director ELMER M. QUADE

Address Hughesville, MD

19. 1-2 Date rec'd by registrar 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Charles

City or town Hughesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 1945, at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 30, 1945, to Dec. 31, 1945

and that I last saw her alive on Dec. 31, 1945

Immediate cause of death Congestive heart failure

Due to Hypertensive heart disease

Due to Chronic diffuse glomerulonephritis

Other conditions Unknown

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE James L. MacKenna, M.D. or other

Address Sa Plate, Md. Date signed 12-31-45

